Established Patient Update Sheet

Last Name:_____ First Name:_____ DOB:_____
Email Address (for providing your electronic medical record summary to you):_____

Has your contact information changed since your last visit? YES NO
New Address:_____ City:_____ State:____ Zip:_____
New Phone Number: Home (___)_____ Work (___) _____Cell (___) _____
OK to text appointment reminders to cell? YES NO
Has your Insurance changed since your last visit? YES NO
****Please present front desk with new card***
Primary Health Insurance Name:_____ ID#:_____
Name of Subscriber:_____ Subscriber's DOB: _____
Secondary Health Insurance Name:_____ ID#: _____
Name of Subscriber:_____ Subscriber's DOB: _____
Vision Insurance Name: _____ ID#: _____
Name of Subscriber:_____ Subscriber's DOB: _____

PERSONAL HEALTH HISTORY
*Have you ever been diagnosed with any of the following: ____Healthy with no medical diagnosis

___Diabetes	___Hypertension	___Tuberculosis
___Thyroid Disease	___Stroke	___Kidney Disease
___Heart Disease	___Arthritis	___Cancer
___Asthma	___Psychiatric Disorder	___Immune Problems
___Chest Pain	___Shortness of Breath	___Regular Coughing
___Coughing up Blood	___Bleeding Problems	___Night Sweats
___Bloody Urine/Stool	___Ringing in Ears	___Loss of Balance
___Swollen Glands	___Unusual Weight Loss	___Frequent Headaches

Other Health Issues:_____
*Please list all Drug Allergies:_____ **No Known Drug Allergies**___
*Please list all current Medications/Strengths:_____
_____ **No current medications** ____
*Preferred Pharmacy Name and Location:_____
*Please list all past surgeries:_____

How often do you drink alcohol?	___Never	___Occasional	___Heavy
How often do you smoke cigarettes?	___Never	___Occasional	___Heavy
How often do you use illegal drugs?	___Never	___Occasional	___Heavy
How often do you intake caffeine?	___Never	___Occasional	___Heavy

*Primary Care Physician:_____

FAMILY HISTORY
Has anyone in your immediate family been diagnosed with any of the following:

___Glaucoma	___Macular Degeneration	___Crossed Eyes
___Color Blindness	___Retinal Detachment	___Cataracts
___Keratoconus	___Cancer	___Diabetes
___Lazy Eye	___Stroke	___Heart Disease

Patient Signature:_____ Date:_____
Parent/Guardian Signature (if patient is a minor):_____
Printed name of Parent/Guardian and relation to minor:_____